

Case Number:	CM15-0179319		
Date Assigned:	09/21/2015	Date of Injury:	11/15/2013
Decision Date:	10/27/2015	UR Denial Date:	08/19/2015
Priority:	Standard	Application Received:	09/11/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Indiana, New York
 Certification(s)/Specialty: Internal Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 36 year old male, who sustained an industrial injury on 11-15-2013. He reported traumatic injuries to the face and head, right elbow, right ankle, and right pelvis from a thirty foot fall. Diagnoses include fracture of the nose, elbow fracture, right ankle fracture, concussion with loss of consciousness, posttraumatic headache, traumatic brain injury and posttraumatic stress disorder; and status post-surgical repair of the elbow, nose, arm, and dental surgery, unspecified. Treatments to date include activity modification, medication therapy, speech therapy, and physical therapy, and biofeedback therapy. The medical records documented on 5-27-15, he reported ongoing difficulty swallowing and episodes of fainting and passing out. Currently, he complained of ongoing memory loss where "he loses hours at a time." It was documented he starting cognitive behavioral therapy and "feels like it is improving his symptoms." In addition, he reported ongoing headaches, dizziness, irritability, and ongoing pain in the right ankle. On 8-10-15, the neuropsychology treatment note documented ongoing episodes of passing out. The physical examination documented increased distress as evidenced by a greater heart rate with images presented. The provider documented dizziness is triggered by external movement in the periphery and may be a factor in syncopal episodes. The treating diagnoses included late effect of traumatic brain injury and syncope. Paced breathing was taught and demonstrated on this date with evidence of reducing heart rate. The plan of care included six additional cognitive rehabilitation sessions to involve building skills for symptom control, and "no longer psychotherapy." The appeal requested six (6) cognitive rehabilitation sessions,

sixty (60) minute long visit (24 units). The Utilization Review dated 8-19-15, denied the request stating "a lack of functional improvement as defined in the California MTUS Guidelines."

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Cognitive rehabilitation x6 60 minute visits: Upheld

Claims Administrator guideline: Decision based on MTUS Stress-Related Conditions 2004.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Psychological treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Cognitive behavioral therapy (CBT).

Decision rationale: Pursuant to the Official Disability Guidelines, cognitive rehabilitation times 6, 60 minute visits is not medically necessary. Cognitive behavioral therapy guidelines for chronic pain include screening for patients with risk factors for delayed recovery including fear avoidance beliefs. Initial therapy for these "at risk" patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after four weeks if lack of progress from physical medicine alone. Initial trial of 3 to 4 psychotherapy visits over two weeks. With evidence of objective improvement, up to 6 - 10 visits over 5 - 6 weeks (individual sessions). In this case, the injured worker's working diagnoses are late effect of traumatic brain injury; and syncope. The date of injury is November 15, 2013. Request for authorization is August 13, 2015. The documentation shows the injured worker sustained a traumatic brain injury and manifests cognitive deficits. The injured worker is ambulatory. According to the most recent progress note dated August 10, 2015 (by the requesting psychologist), the injured worker received five out of eight neuropsychology treatments. The treating provider is requesting an additional six treatments. The injured worker sustained to passing out episodes and missed two treatments. There is no documentation demonstrating objective until improvement. The injured worker remains temporarily totally disabled and continues to complain of palpitations, anxiety with syncope. The guidelines recommend a trial of 3 to 4 psychotherapy visits and with evidence of objective functional improvement 6-10 may be indicated. The injured worker received, at a minimum, #8 sessions (authorized). Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation demonstrating objective functional improvement and continued symptoms of anxiety, palpitation and syncope, cognitive rehabilitation times 6, 60 minute visits is not medically necessary.